

October 16, 2019

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
H-222 U.S. Capitol
Washington, DC 20515

The Honorable Kevin McCarthy
Republican Leader
U.S. House of Representatives
H-204 U.S. Capitol
Washington, DC 20515

Dear Speaker Pelosi and Republican Leader McCarthy:

The undersigned medical organizations remain committed to working with Congress to seek a balanced legislative solution to protect patients from unanticipated (“surprise”) medical bills that can occur when gaps in health insurance coverage lead them to receive care from out-of-network physicians or other providers. We represent hundreds of thousands of practicing physicians who provide care to millions of Americans every day in a variety of practice settings. We strongly believe that, in situations where a coverage gap occurs and patients unknowingly or without a choice receive care from an out-of-network physician or other provider, patients should be held harmless for any costs above their in-network cost-sharing, and their cost-sharing should count toward deductibles and out-of-pocket maximums. Patients should be completely removed from any subsequent payment disputes between their health insurance company and an out-of-network provider when they experience an unanticipated coverage gap.

After ensuring that patients are protected, it is essential that any legislation does not create new imbalances in the private health care marketplace. The health insurance market is already [heavily consolidated](#), which can result in artificially low payment rates and anticompetitive harms to both consumers and providers of care. We are highly concerned that the rate-setting provisions in current bills further shift marketplace leverage to health insurers at the expense of providers. As a consequence, this imbalance will likely lead to access problems for patients seeking hospital-based care from on-call specialists, as well as precipitate staffing shortages in rural areas and other underserved communities. Furthermore, according to the [Congressional Budget Office](#), “The vast majority of health care is delivered inside patients’ networks, and more than 80 percent of the estimated budgetary effects of title I [of the “Lower Health Care Costs Act” (S. 1895)] would arise from changes to in-network payment rates.” In other words, in-network providers who have not contributed to the problem will bear the impact of the rate-setting scheme. CBO reached the same conclusion in its analysis of [Title IV of H.R. 2328](#), the “No Surprises Act.”

As House committees continue to work toward a legislative solution, we believe there is strong evidence that pursuing a different, balanced approach would achieve the goal of protecting patients from surprise bills while maintaining their access to care in more competitive markets. This balanced approach includes a timely upfront, commercially reasonable payment for out-of-network services, and an efficient independent dispute resolution (IDR) process designed to incentivize health insurers to make a fair initial offer of payment for out-of-network care provided to their customers while also preventing bills from physicians or other providers that are outside generally acceptable ranges. It also should encourage, rather than discourage, health insurance companies and providers to contract for in-network care to avoid adverse market distortions or patient access problems.

The IDR process should be structured so that a range of factors is considered in determining a mutually fair payment—such as the complexity of the service rendered, the experience of the physician providing the service, the rate that physicians or other providers charge for the service in a geographic area, and

commercial insurance data from an independent and transparent source. There is strong, compelling evidence that this approach is successfully resolving out-of-network payment disputes between health insurance companies and out-of-network providers without negatively impacting patient access to hospital-based services or increasing insurance premiums.

In an October 1, 2019 [Op-Ed](#) in the *New York Daily News*, Linda Lacewell, the Superintendent of the New York State Department of Financial Services, said that from March 15, 2015 through the end of 2018, the New York out-of-network law has saved patients more than \$400 million in emergency services alone, reduced out-of-network billing in New York by 34 percent, and lowered in-network emergency physician payments by 9 percent. She said: “This law protects consumers from out-of-network bills from emergency physician services in a hospital and surprise bills in hospitals and other out-patient settings. It includes extensive consumer protections, including holding consumers harmless for costs beyond in-network deductibles, copays or coinsurance, improved disclosure, enhanced network adequacy requirements, expanded appeal rights, and easier claims submission. At the center of the law is a process called Independent Dispute Resolution (IDR), which removes consumers from billing disputes. Instead, providers and health plans settle billing, and use the IDR process for disputes.”

While some insurance companies have claimed that the proposed IDR process would be too cumbersome, that is not the case in reality. In New York, for example, the process essentially involves visiting www.dfs.ny.gov and filling out a two-page form. This contrasts with the often voluminous filing requirements necessary for physicians and other providers to obtain prior authorization from many health insurance companies just to provide covered benefits to their patients, even for mental health and substance use disorder treatments.

In July, the House Energy and Commerce Committee took a critical step forward by adopting an IDR process in Title IV of H.R. 2328, the “No Surprises Act,” as a backstop should the bill’s underlying payment methodology not result in a resolution that is acceptable to both parties. However, additional improvements should be made going forward to ensure that the bill has a fair, market-focused approach that retains strong protections for patients while preserving the viability of physician practices.

Specifically:

- The \$1,250 threshold to trigger the IDR process should be lowered; it is too high to ensure adequate reimbursement for claims that do not meet this amount. Any threshold should be set at a level that is realistic and based on the distribution and range of real-world claims and payments.
- The IDR threshold should allow for batching of claims that involve identical plans and providers and the same or similar procedures that occur within reasonable timeframes, with consideration given to the size and resources of the individual or group providing those services. This is to ensure that providers, regardless of specialty and cost of services, can benefit from a fair IDR process.
- The initial payment of a median in-network rate should be changed to reflect a commercially reasonable rate that is fair to all stakeholders in the private market; these rates should include actual local charges as determined through an independent claims database.

- Median in-network rates established by individual insurers are problematic because they do not rely on a known independent, transparent, and verifiable database. Insurer datasets cannot be relied on for these rates, as proven by the 2009 class action settlement against United Health Care for \$300 million in which the usual, customary, and reasonable database for determining out-of-network payments operated by its subsidiary, Ingenix, was found to be inaccurate and unreliable. More recent efforts by the Georgia Department of Insurance to collect plan-reported data on mean and median contracted payment rates yielded similar inconsistencies and was abandoned.

Finally, a balanced solution requires that insurers be held accountable for addressing their own contributions to the problem. Any legislation addressing surprise billing should also establish strong, measurable, and enforceable network adequacy requirements, as well as require stronger enforcement of federal mental health and substance use disorder parity and prudent layperson laws. This is essential to ensure that insurers maintain adequate provider networks and do not force patients to go out-of-network to access care that they need.

We look forward to working with the Congress to make these refinements as the process moves forward and ensure that any final bill represents a fair, market-based approach that treats all stakeholders equally while protecting patient access to care.

Sincerely,

American Medical Association
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation.
American Association for Geriatric Psychiatry
American Association of Child & Adolescent Psychiatry
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Cosmetic Surgery
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons

American Contact Dermatitis Society
American Medical Women's Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Laser Medicine and Surgery
American Society for Radiation Oncology
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Dermatopathology
American Society of General Surgeons
American Society of Hematology
American Society of Neuroimaging
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Association of American Medical Colleges
Association of University Radiologists
College of American Pathologists
Congress of Neurological Surgeons
Medical Group Management Association
National Association of Spine Specialists
North American Neuro-Ophthalmology Society
Renal Physicians Association
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Critical Care Medicine
Society of Hospital Medicine
Society of Interventional Radiology
Society of Thoracic Surgeons
Spine Intervention Society

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc

Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

cc: The Honorable Lamar Alexander, Chairman
U.S. Senate Committee on Health, Education, Labor & Pensions

The Honorable Pat Murray, Ranking Member
U.S. Senate Committee on Health, Education, Labor & Pensions

Honorable Nancy Pelosi
Honorable Kevin McCarthy
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The Honorable Frank Pallone, Jr., Chairman
House Committee on Energy & Commerce

The Honorable Greg Walden, Ranking Member
House Committee on Energy & Commerce

The Honorable Richard Neal, Chairman
House Committee on Ways and Means

The Honorable Kevin Brady, Ranking Member
House Committee on Ways and Means

The Honorable Bobby Scott, Chairman
Committee on Education & Labor

The Honorable Virginia Fox, Republican Leader
Committee on Education & Labor